MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Main Rehab & Diagnostic 3710 Rawlins, Ste. 1400 Dallas, TX 75219	MDR Tracking No.: M4-04-2845-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Winn Dixie Louisiana, Inc. c/o Harris & Harris P.O. Box 162443 Austin, TX 78716 BOX 42	Date of Injury: Employer's Name: Winn Dixie Louisiana, Inc. Insurance Carrier's No.: A11120179900010111

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		**CPT Code(s) or Description**	**Amount in Dispute**	**Amount Due**
From	**To**			
07/14/03	**07/31/03**	**99213, 97265, 97110, 97032, 97750-MT, 95851**	**$519.00**	**$519.00**

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary dated 11/05/03 states in part, "…The carrier has inappropriately reduced the medical fees which were charged according to the TWCC Fee schedule at the time that services were rendered. Carrier has raised **NO OTHER ISSUES ON THE EOB'S**…"

PART IV: RESPONDENT'S POSITION SUMMARY

Position Summary dated 12/08/03 states in part, "…In response to the requestors' additional documentation, the carrier is currently investigating the validity of the PPO reduction…"

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

The requestor's agent, ___, sent an e-mail on 2/3/05 indicating the dispute was still active and no additional payments had been made.

- The submitted EOBs for the dates of service in dispute indicates the insurance carrier reduced the MFG MAR amount. The Respondents response to MDR alludes to a PPO contract; however, no payment exception codes were used, which is in violation of Rule 133.304(c). Per the 1996 Medical Fee Guideline Evaluation & Management Ground Rule (IV)(C) for CPT Code 99213 for dates of service 07/14/03 through 07/31/03; Medicine Ground Rule (I)(A)(10)(a) for CPT Codes 97265, 97110, and 97032 for dates of service 07/14/03 through 07/31/03; and Medicine Ground Rule (I)(E)(3) and (4) for CPT Code 97750-MT for date of service 07/21/03 and CPT Code 95851 for date of service 07/31/03 submitted SOAP notes support the services were rendered as billed. Additional reimbursement in the amount of $519.00 is recommended.

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $519.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

	Marguerite Foster	02/11/05
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____